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ABSTRACT

There is considerable awareness among Israeli mental health workers and citizens of the importance of differentiating between acute or chronic reactions to severely stressful life situations and manifestations of mental illness and anxiety, or developmental and adjustment disorders. Israeli mental health workers have become expert and are heavily committed to treating stress-related phenomena. While manuals are available for dealing with stress reactions in school children, teachers, and mental health personnel themselves, these manuals present little systematic data on the pervasiveness of stress reactions. In spite of the ubiquitous nature of war stress-related phenomena in Israeli society, there have been no large-scale epidemiological studies of stress-related reactions and disorders in Israeli children and youth for any decade. Two major reviews of the clinical studies in the field cite data on anxiety levels in children as a function of the ideological and ecological features of their community, demographic variables, and the degree of traumatization they have faced. Ideological biases of both the investigator and the clients can determine what is attended to and how it is interpreted and treated. The ideological bias of the investigator can cause researchers to diagnose stress-related psychopathlogy in children where it does not exist or to avoid seeing it where it does. Such ideological biases complicate the process of identifying and treating Israeli children who may suffer from war-related posttraumatic stress disorders. The same caveats may also apply to working with Palestinian children. (NB)

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Childhood PTSD in Israel:

A Cross Cultural Frame of Reference [1]

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In discussing stress-related phenomena in Israel, an effort is made in this paper to identify those features of the society that explain in part the incidence and character of stress reactions and the kinds of interventions employed in Israel.

Awareness of Stress-Related Disorders in Israel

There is considerable awareness among Israeli mental health workers and among citizens from all walks of life in Israel of the importance of differentiating between (1) acute and chronic reactions to severely stressful life situations on the one hand, and (2) manifestations of mental illness (e.g., schizophrenia, affective disorders), and anxiety, developmental, and adjustment disorders. This awareness is due to several factors:

(1) English is a second language for all Israelis. As a consequence of the British occupation of Palestine, there is a pervasive cultural tropism in Israel toward the English-speaking world in general, and the United States in particular. There are close working relationships between Israeli mental health workers and their colleagues in the United States, the world leader in these developments. Israelis train in the United States, attend conferences and workshops, rely heavily on books published in the United States, and are well aware of the new developments in diagnosis of posttraumatic stress reactions and disorders, in crisis intervention, and in stress management of children and youth.

(2) The century-long state of war between the Jewish people -- living in the pre-1948 Palestine and subsequently in the State of Israel--and their Arab neighbors, both within and outside the borders of Palestine, has been an object lesson in traumatic stress reactions and post-traumatic stress disorders. Six wars in the last 40 years, thousands of terrorist incursions within its narrow borders, countless rocket attacks in the north, and the ongoing toll of the Palestinian uprising--have all contributed to a heightened awareness of and increasing familiarity with the key concepts associated with the stress and coping paradigm--precipitating stressors, intrapersonal resources, interpersonal support systems, coping styles, and stress reactions.

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(3) Apart from the contribution to community cohesiveness of the continuing Arab-Israeli conflict, there exists within Israel a sense of community that transforms the direct experiences of the few into the empathic experiences of the many. As a consequence, no Israeli is a stranger to the role of highly stressful, extraordinary life events--war and non-war related--in affecting adversely psychological adjustment in children and youth.

(4) There is a parallel between key concepts within the stress and coping paradigm and dominant features of Israeli national character. The concept of personal resources, for example, dovetails with internal locus of control and personal responsibility for one's actions. Cross cultural studies (Parsons & Schneider. 1974) have shown that Israeli college students are more internal than their counterparts in other countries, Western and non-Western, in attribution of responsibility for what happens to them. Israelis of Western background also believe that they should be in control of events rather than be controlled by them (Lazarus, 1982).

Second, the concept of interpersonal support systems fits in with the Israeli socialist model of giving and receiving help and of society's responsibilities to the individual. You are supposed to solve your own problems, but you are entitled to receive help from society in doing so. This model is proposed as an ideal to live by, and its application is amply rewarded.

(5) Exposure to adverse stressors from any source in Israel is inescapable, but especially manifestations of the Arab-Israeli conflict. No Israeli lives more than five miles from Palestinian Arabs who may harbor hostile intentions toward his person or property. Moreover, as we have said, what affects one child or one family is broadcast to countless others. Male family members serve in the regular army or in the reserves until age 55, so that all children become personally aware of war and its toll in the course of their development. Children have frequently been the direct victims of terrorist attack: Some were kidnapped from their neighborhoods and killed by adult Arabs, others were injured or killed as hostages, and still others by petrol bombs or rockets.

This exposure is magnified by the mass media who devote many viewing hours to documentaries, human interest anecdotes, and professional discussions on coping with disaster and its aftermath. The few television channels, radio channels, and daily newspapers that compete for the public's eye and ear, highlight the human toll of war, terrorism, and violence and the heroic coping by many with these stressful situations.

(6) The aperiodic recurrence of these stressors (with families suffering injury or death of its members over three or more generations) during the past 40 years of the Jewish State, and the previous 70 years of Zionist settlement have transformed Israel into a natural breeding ground and a training laboratory

for posttraumatic stress syndromes (Lazarus, 1982; Milgram, 1986).

The Incidence of Stress-Related Disorders in Israeli Children

Given the ubiquitous nature of war stress-related phenomena in Israel society, one might assume that the incidence of stress-related reactions and disorders in Israeli children and youth would be well known. Yet in point of fact, there are no large-scale epidemiological studies of the question for any decade, including the current one. That large numbers of Israeli children are directly exposed to threatening stressors and that still larger numbers are indirectly exposed is freely acknowledged. The lack of survey data on stress fallout is somewhat surprising, given the level of professional and lay awareness about these phenomena.

On the one hand, Israeli mental health workers have become expert and are heavily committed to treating stress-related phenomena (cf. work of Ayalon, 1979; Klingman, 1978; Lahad & Cohen, 1988). There are excellent manuals of instructions for dealing with stress reactions in school children, teachers, mental health personnel themselves (e.g., Lahad & Cohen, 1988). On the other hand, these manuals of individual and group intervention and therapeutic activity present little systematic data on the pervasiveness of the phenomena they are designed to treat. We have no figures on the incidence of these problems in Israeli children within pre-1967 borders or in Judea, Samaria, or Aza. And without a comprehensive picture of the needs, it is difficult to develop an program to meet these needs.

Two major reviews of the clinical studies in the field--(1) War-related stress in Israeli children and youth, written by me in Handbook of stress: Theoretical and clinical aspects (L. Goldberger & S. Breznitz, Eds.), 1982; and (2) Children under stress, by Raviv and Klingman, in Stress in Israel (S. Breznitz, Ed.), 1983--cite data on anxiety levels in children as a function of the ideological and ecological features of their community (kibbutz, moshav, development town, big city), as a function of demographic variables (age, sex, social class), and as a function of the degree of traumatization (death and/or injury of family members, friends, strangers, etc.).

Both chapters close with unsubstantiated positive, optimistic observations. Raviv and Klingman state that Israeli children appear remarkably well adjusted (.."one is struck by the lack of visible signs indicating the strain to which they are subjected. Life is stronger than the stressful reality, and in spite of their sensitivity, children are sufficiently ..flexible to adapt" (p. 158). In my chapter, I referred to opportunities for personal growth as a function of successive coping with war-related stressors, suggesting that some children and youth achieve better --rather than poorer--functioning as a consequence of adverse events. These unsubstantiated conclusions undoubtedly reflected the prevailing Zeitgeist in the 1970's and early 1980's that all

was well in Zion.

More recent followup data of children who witnessed the death of parents, siblings, or friends in terrorist attacks suggest that some are unable to fill the void caused by the demise of loved ones and to achieve the developmental milestones of adolescence and young adulthood (Ayalon & Soskis, 1986; Dremen, 1989). The extent of long-term maladaptive sequelae in children exposed to less traumatic events (e.g., secondary victims who witness, but are not the direct victims of, the fire bombing of a car, attempted kidnapping by terrorists, etc.), or other acts of violence, remains largely unknown.

Lack of data has not deterred members of the mental health professions, educators, and politicians in Israel from making sweeping pronouncements about the mental health or illness of Israeli society in general, and Israeli soldiers and children in particular. These generalizations are often based on theoretical speculation, interpretation of a few clinical cases or quantitative findings based on small samples, or on methodologies of questionable validity.

The Ideological Bias of the Onlooker-Interventionist

Such generalizations are vulnerable to the double bias effect, to be defined in what follows. Consider the issue of PTSD and other stress-related reactions among Israeli soldiers serving in Judea, Samaria, and Aza since the outbreak of the Palestinian uprising two years ago. Many mental health professionals have insisted that the soldiers, if not the society as a whole, were becoming demoralized or immoralized by the character of their military service. Yet, authoritative, objective voices (Reuven Gal, Director of the Israel Institute of Military Studies, an independent research foundation, in recent reports) state that the available evidence, at least in the case of the Israeli Defense Forces, does not support these claims.

What is happening in Israel is readily understandable and is not unique to that society. Professionals of the current period--researchers and clinicians alike--are subject to the selective influences that operate in all societies in periods of national stress and in their aftermath. They see what they wish to see and interprete findings according to their ideological leanings. If one is convinced of the justice of the Palestinian cause and their demand for a Palestinian State now, then it follows that Israeli soldiers are behaving monstrously to people yearning to be free, and that they must be paying a monstrous price for it--in psychic numbing, in the hardening of their moral arteries, and in acquiring other maladaptive defense mechanisms. If we find a few soldiers whose words and overt behavioral symptoms match our expectations, we cite their cases as evidence. If we fail to find supporting data or, in fact, find contradictory data, we engage in selective denial, rationalization, and other mental mechanisms that permit us to retain our original conclusions.

Ideological bias may work to minimize the extent of a phenomenon as well as to maximize it. Members of the mental health professions may insist in a given circumstance that there are no mental health problems. US Army mental health personnel made such pronouncements in the early years of the Viet Nam War, largely on the basis of judicious definition of phenomena and careful selection of data that would support the viability as well as the legitimacy of the American intervention (Milgram & Hobfoll, 1986). Later events demolished these earlier assertions, and mental health professionals in the United States today compete with one another in announcing ever higher estimates of the psychic price paid by Viet Nam veterans (Kulka et al., 1990). One may ask whether these mental health workers have gone too far today in the maximization of a war-related psychiatric phenomenon as their predecessors did in its minimization 25 years earlier?

Closer to home, Wiztum and his colleagues (1989) have analyzed systematically the medical records of the Israeli Defense Forces from 1948 to 1974 for data on PTSD and report two interesting findings: Officially the disability did not exist, but in practice it was treated--somewhat better, in fact, in the earlier wars than in the 1973 war.

The Ideological Bias of the Victim-Client

We have been speaking of the ideological bias of the investigator, the observer, the reporter, in determining what is attended to, and how it is interpreted and treated. There is, however, a second source of bias, hence the term double bias, that of the subject, the client, and in the present instance, the child or youth. If one enters a Israeli community in Judea or Samaria and interviews children about their reactions to upsetting events in their communities or on the highways to and from their communities to school or other cities and towns, one is likely to receive a carefully censored report. The children are well aware of "the hostile press", of the ideological leaning of their parents and the leaders of their community, and may respond in kind. Children may even minimize their personal distress in talking with professional people within their own communities. To acknowledge adverse stress reactions is to acknowledge weakness of resolve and to undermine some of the arguments for permitting Jewish settlers to remain in these contested areas after the conclusion of peace negotiations. As a consequence of these pressures, children, their parents, and their teachers may present a level of mental health at odds with the underlying reality.

In retrospect, this kind of bias may have accounted for some of differences in anxiety reactions obtained during the past two decades between children exposed to violent events who lived in kibbutzim as compared to children living in moshavim or development towns. The former are well aware of kibbutz ideology and may have presented a braver front than was warranted by their personal experience.

Krystal (1978) examined children living in the Jordan Valley, and compared those from frequently shelled communities with others from non-shelled communities. He reported three findings: (1) There were no differences in manifest anxiety reactions between shelled and non-shelled children; (2) There were differences on a subtle measure of anxiety, bruxism (habitual clenching and grinding of teeth), with shelled children displaying more bruxism than non-shelled; (3) When exposed to a stress film depicting a terrorist atatck on an agricultural community, the shelled children reported far higher anxiety levels than the non-shelled controls.

These findings suggest (1) the need for special caution in examining children and youth so as to minimize possible distortions in obtaining, analyzing and interpretating data that may stem from observer-interventionist bias, client bias, or both; (2) the importance of situation specificity in accounting for behavioral discrepancies: self report data obtained under relaxed conditions may differ markedly from self report obtained in stressful conditions, even when children respond freely without ideological bias; that is, children repeatedly exposed to upsetting situations report more adverse anxiety reactions to relevant stressful cues than children not previously exposed; and (3) the importance of using a number of research methods to identify stress-related phenomena in children--teacher or parent observations in addition to children's reports of their subjective emotional states or their current behavioral level.

The Psychiatric Fallout of Ideological Bias

I am not trying to suggest that war is healthy for children and other growing things. On the contrary, war is the ultimate human tragedy, in which people employ their intellectual and emotional resources to the fullest degree to injure and kill other humans in the service of their perceived interests. The politicizing of one's scientific and professional efforts is less tragic and injurious than war itself, but its harmful consequences should not be ignored.

Ideological considerations in the diagnosis and treatment of mental, emotional and behavioral disorders are not only reprehensible from a scientific-ethical point of view, they are also harmful to the potential clients, patients, or victims. They are harmful whether the ideological bias in question seeks to exaggerate or minimize the actual reality; and wherever they occur--in the work of Soviet psychiatrists treating political dissidents or Jewish refusniks in the pre-Gorbachov era, or in the work of mental health personnel in Israel, in the service of their ideological convictions, however sincerely held.

Why harmful? The combat stress reaction literature suggests that a major variable affecting immediate stress reactions and long-term chronic residuals in soldiers is the standards or expectancies set by the military authorities and the mental health personnel with reference to the nature and implications of

the soldier's current condition (Milgram & Hobfoll, 1986). If long lasting pathology is anticipated and implicitly encouraged--because of ideological bias and behavioral projections, a disservice is being done to the soldier. When directed to play a maladaptive psychiatric role to confirm to the ideological bias of the therapist, a soldier is at far greater risk for succumbing to a chronic, possibly irreversible, disorder than otherwise. On the other hand, when soldiers at risk for combat stress reactions are told that there is nothing wrong with them, their future well being is again jeopardized because they are not receiving the professional help they require (Milgram & Toubiana, 1988).

The same argument may be made for mental health workers of any persuasion in diagnosing stress-related psychopathology in children where it isn't or trying to avoid seeing it where it is. These remarks are based on my observations of Israeli children and the problems of their identification and treatment. The same caveats may also apply to work with Palestinian children.

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